Chesterfield Family Practice Center, P.C.

2500 Pocoshock Place, Richmond VA 23235 Phone: (804) 276-9305
Fax: (804) 276-8324 .chesterfieldfamily.com

Authorization:

Consent to Treat Patient-Without Parent/Legal Guardian

I have the legal right to preauthorize Chesterfield Family Practice Center, P.C. and its personnel to deliver routine medical treatment and services to my child without a parent or legal guardian. Routine medical care and interventions may include, but are not limited to: medical evaluation, physical exam, routine immunization, injections, and lab work.

I _____request and authorize Chesterfield Family Practice Center, P.C. and its personnel to deliver routine medical care to my child listed below as may be deemed necessary or advisable in the diagnosis and treatment of the minor child:

Childs Name: _____Date of Birth: _____
Allergies: _____
Current Medications: _____
Chronic Conditions: _____

Limitations:

Identify any specific limitation on the kinds of medical services for which this authorization is given. (If none, state "none")Parental Contact Information for questions regarding treatment of the child:

Parent name: _____
Cell Phone: _____ Home: _____ Work: _____
Address:
_____

I hereby authorize _____ to bring my child to his/her appointment if I am unable to attend. I understand that medical advice will be relayed to them on my behalf. I understand and agree that the signature and dates on the form will not expire without written notice or in case that a minor becomes the age of 18, and that a photocopy of this form is considered valid as the original.

Relationship to Child of above named person: _____

Parent or Legal Guardian Signature:
_____

Date:_____